PREVALENCE AND TREATMENT OF DEPRESSION AMONGST INSTITUTIONALIZED ELDERLY: LITERATURE REVIEW

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Abstract:

Depression is considered treatable but high prevalence of depression is common amongst elderly living in institutional care setting. With anticipated increase in population of institutionalized elderly due to global ageing, the need to understand the reasons to high prevalence in this setting and the effectiveness of treatment available to this population becomes necessary.

Aim: The study aims to find out the causes of high prevalence of depression in institutional care setting and types of treatment available to population of elderly in this care setting**.** Bandura´s Socio-cognitive theory guides the study and provides a multidimensional view on the topic and research questions. The study aims to answer the following research questions,
1) What are the causes of high prevalence of depression in institutional care?
2) How effective is depression treated in institutionalized care setting

Method: Qualitative method (Literature review) was used for the study, with deductive content analysis applied in the analysis of selected article.

Results: Results shows that prevalence and treatment of depression in institutional care setting is affected by three main factors namely: Environmental factors, Personal factors and Behavioral factors. Also, pharmacological method (Medication) is the most frequently used form of treatment despite the availability of other more tolerant non-pharmacological therapies

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Tiivistelmä:
Masennus (Depressio) on yleistä vanhuksilla, jotka asuvat laitoshoidossa. Depressio on kuitenkin hoidettava sairaus. Ikääntyvän väestön lisääntyessä myös laitoshoidon tarve kasvaa. Samalla kasvaa tarve ymmärtää syitä masennuksen korkeaan esiintyvyyteen, sen syihin ja hoidon vaikuttavuuteen vanhusten masennuksen hoitamisessa.

Tavoite: Tutkimuksen tarkoitus on löytää syitä masennuksen korkealle esiintymiselle laitoshoidossa ja hoitomuotoja, jotka soveltuvat vanhuksille laitoshoidossa. Banduran Sosio-kognitiivinen teoria ohjaa tutkimusta ja todistaa moniulotteisen näkökulman aiheeseen ja tutkimus vastaa seuraaviin tutkimuskysymyksiin,
1) Mikä aiheuttaa masennuksen suuren esiintyvyyden laitoshoidossa?
2) Kuinka vaikuttavaa on masennuksen hoito laitoshoidossa?

Menetelmä: Kvalitatiivinen menetelmä (kirjallisuus katsaus) oli käytössä tutkimuksessa, deduktiivinen sisältö analyysi sisältyy valittuun artikkeliin.

Tulokset: Tulekset osoittavat että masennuksen hoito ja sen vaikuttavuus laitoshoidossa on yhteydessä kolmeen seuraavaan päätekijään: ympäristötekijät, persoonalliset tekijät ja käytökselliselliset tekijät. Kuitenkin lääkkeellinen hoito (lääkitys) on yleisin käytetty terapiamuoto huolimatta siitä että muitakin ei lääkkeellisiä hoitomuotoja olisi saatavilla.

Avainsanat:	Masennus,Riistaveden Palvelukoti Oy, yleisyys, Vastavuoroinen determinismi,
Sivumäärä:	57
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FÖRORD / FOREWORD

I dedicate this study to my family, who has been there for me all through my studies, especially to my son Zizi. Their understanding and support has made it possible for me see this through.

Special thanks to my supervisor Solveig Sundell for her guidance not only throughout the research process but also throughout my studies here at Arcada and my development as a research scientist. I also say thanks to my second reviewer Annika Skogster for her effort in reviewing this work

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Thank you all.

1 INTRODUCTION

Depression is generally common amongst elderly individuals but its prevalence is considerably higher in Institutionalized elderly when compared with the General population. Tam and Chiu (2011 p.13), attributed late life depression as being associated with significant morbidity, including deficits in range of cognitive function and considerable influence on functional impairment and disability while in elders who have co-existing chronic medical conditions, the presence of depressive symptoms increases role impairment, utilization of medical services and treatment cost, decrease patients compliance with medical treatments and alters disease course, leading to higher mortality and disability. According to Glass, Karl & Berkman,(1997) in Bulut.S (2009 p.21), the prevalence of depressive symptoms in the general population is at its lowest incidence during the middle- age years ,increases throughout late adulthood, and reaches its highest level in adults age 80 or above. Other experts reported that among elderly who live in the community, the prevalence of depressive symptoms has ranged from 11% to 44% with an average of 20% while About 43 % of the institutionalized elderly, however, were diagnosed as having depression (Reeker, 1997 in Bulut.S 2009). This is similar to the findings of Roberts.L.K et al., (2004) who stated that prevalence is higher among geriatric patients in acute care hospitals and nursing homes. Among institutionalized older persons, major depression is found close to 15 percent, with another 15 to 20 percent having depressive symptoms, incidence rates of these disorders in nursing homes are in similar range (Rovner et al., in Roberts.L.K et al 2004; Parmelee et al., 1992a in Roberts. L.K et al 2004)With expected future increase in elderly population and longevity ,there may be a corresponding increase in institutionalized elderly population as well as higher projected prevalence of depression in Institutional settings in future. Thus, from a careers point of view , understanding the causes of high prevalence of depression amongst institutionalized elderly and its treatment , especially as regards non-pharmacological interventions that has shown positive results is an important step in tackling this major health care issue.

Bandura's social Cognitive Theory (SCT), acted not only as a guide but as the Major theoretical framework. It has been widely applied to health behavior in the area of pre-

vention, health promotion as well as modification of unhealthy lifestyles for many risk behaviors. One major stereotype or myth is that depression is part of the ageing process and its prevalence in elderly institutions may also be attributed to Ageing but Bandura (2004 p. 143), describes social Cognitive Theory (SCT) as a multifaceted causal structure in which self-efficacy beliefs operate together with goals, outcome expectations, and perceived environmental impediments and facilitators in the regulation of human motivation, behavior, and well-being. Belief in one's efficacy to exercise control is a common pathway through which psychosocial influences affect health functioning and this core belief affects each of the basic processes of personal change—whether people even consider changing their health habits, whether they mobilize the motivation and perseverance needed to succeed should they do so, their ability to recover from setbacks and relapses, and how well they maintain the habit changes they have achieved. Bandura (2004) also sees Human health as a social matter, not just an individual one and proposes that a comprehensive approach to health promotion also requires changing the practices of social systems that have widespread effects on human health. The author views depression from a social Cognitive Theory (SCT) perspective of not being prevalent by just an individual causative factor(Ageing) but from a multifaceted causal structure in which Environmental factors, Personal factors and behavioral factors all contribute to the prevalence of depression in institutional care setting. The author is able to show the effect of various treatment methods on depressed institutionalized elderly and the likely associated factors that contribute to high prevalence of depression within this setting. The author reviewed previous articles on depression and its treatment as well as how the elderly feel about some treatment methods.

1.1 Motivation for choice of research topic

The motivation for the choice of the research topic was based of the thesis commissioning party interest on the subject and the author's knack for learning and understanding new information as well as investigating the questions posed by the commissioning party during preliminary discussion. The author had approached the commissioning party about a different unrelated topic and possibility of getting it commissioned but was surprised after formal introduction as a Geronom, when asked as to the likely reasons why

there was high prevalence of depression in institutional care setting and what can be done about it. After a thoughtful response and an idea of family involvement in treatment and rehabilitation, the desire to further investigate this question to understand the reason the institution was interested in high prevalence of depression and the need to confirm if the author has given the right response had led to a wider range of information and the selection of this topic as choice for research topic.

1.2 Aim and research questions

This study aims to highlight the problem of high prevalence of depression amongst elderly in Long-term care, its causes, treatment, and best practices in the handling of depression in institutional environment.

The study aims to answer the following research questions,

3)What are the causes of high prevalence of depression in institutional care?

4)How effective is depression treated in institutionalized care setting?

The study was limited to institutionalized care setting due to the higher prevalence of depression within this setting and the desire to present the challenge of tackling this problem considering anticipated increase in institutionalized elderly in future as we experience global ageing.

1.3 Previous research

Previous researches were reviewed by the author in order to grasp a sound knowledge of the topic. Most researches point to a high prevalence of depression among the institutionalized elderly, but while deterioration of health, lack of social resources, loss of established social relationships, stressful event, and the use of depressogenic medications was identified as some of the causes of high prevalence of depression amongst institutionalized elderly, and with some researches suggesting that social factors ,in particular the degree of a person's social network ,have a positive impact on geriatric depression, other researches showed no relationship between social factors and the prog-

nosis of geriatric inpatient depression. There is no exact estimate of the the prevalence of depression in institutional care setting and the variance is dependent on the method of diagnosis and the type of institution from which samples are collected. However figures for all types of depression range from between 7% to as high as 75 %. The real prevalence estimates could perhaps be yet unknown as depressive symptoms are often not recognized because depression is not usually the focus of physician's and nursing personnel as well as its being comorbid with other common institutional problems such as cognitive impairment, medical illness and functional impairment.

In terms of treatment, while depression is considered treatable by antidepressants in several researches, others have pointed out the inconsistent effect of both pharmacological (e.g., side-effect of drugs) and some non-pharmacological therapies (Inconsistent effectiveness). According to Y.Tsai et al (2008 p. 489) more and effective non-pharmacological therapies and strategies alone or with medications are needed to treat or relieve depressive symptoms in older individuals. Using a quasi-experimental design, they found out that self-worth therapy is an easily administered effective non-pharmacological treatment with potential for decreasing depressive symptoms in older nursing home residents.

Similar studies on evolution of depression and antidepressants use in elderly long-stay nursing home residents by Gaboda.D et al, (2011), in their study *"No Longer Undertreated? Depression Diagnosis and Antidepressant Therapy In Elderly Long-Stay Nursing Home Resisdents,1999 to 2007"* , examined the evolution of depression identification and the use of antidepressants in elderly long-stay nursing home residents from 1999 to 2007 and the associated socio-demographic and facility characteristics using a cross-sectional method for long–stay nursing home residents aged 65 and above. The study showed an increase in depression diagnosis and treatment with antidepressant medications, but also suggests need for more research on the assessment of effectiveness of antidepressant prescribing.

Andrews. G (2008) investigated *Reducing the Burden of depression* with the sole objective of considering why the burden of depression persisted. His method was

reviewing the epidemiology and disability associated with depression and find out reasons why depression persist. He concluded that the burden of depression persist because individuals do not seek treatment for their depression when they relapse and effective proactive treatment is not always provided when they do seek it.

Reeve J.L et al (2008) in their study, *Revisiting depression in palliative care settings: the need to focus on clinical utility over validity* - reviewed literature on depression in palliative care clients in other to identify implications for development of clinical practice and individual patients care. They did a qualitative review of depression prevalence studies in palliative care settings and their results was that risk factors may contribute to depression prevalence but through a complex interaction of factors making individual risk levels hard to determine.

Tsai et al (2004) focused on non-pharmacological therapies to treat depression in the elderly in their study on *The Effects of light therapy on depressed elders*. Using an experimental design, they were able to find out that depressive symptoms were significantly reduced in an experimental group at post-test but no significant decline was found in the control group. They therefor concluded based on results that light therapy could be used to decrease depressive symptoms in the elderly.

Djernes.JK (2006) also did a review on the Prevalence and Predicators of depression in populations of elderly. By reviewing databases, they were able to show that prevalence was highest in institutional living and that the main predicators of depressive disorders and depressive symptom cases are: female gender, somatic illness, cognitive impairment, functional impairment, lack or loss of close social contacts, and a history of depression.

In a study on *the Moderating role of perceived social support on the relationship between physical functional Impairment and Depressive symptoms among Chinese Nursing home Elderly in Hong Kong* by Kwok et al (2011), using a cross-sectional survey method and convenience sampling, they were able to get results that shows a

relatively low level of depressive symptoms of elderly in their study than in other studies. They attributed this to the long duration or time(more than 2 years) stayed by participants in the nursing home, causing familiarization with living environment and maybe a better psychological well-being and a lower level of depressive symptoms. They also found out that female elders reported more depressive symptom which is consistent with other studies, but a contradictory result was found on the hypothesis that elderly with higher education level would have a lower level of depressive symptoms. This contradiction was attributed to higher life expectation by elderly with higher education with unexpected institutionalization maybe affecting their self-esteem and self-worth, and thus contributing to more depressive symptoms. Results also showed a higher level of functional impairment was related to more depressive symptoms, no significant correlation between perceived family support and depressive symptoms, but a higher level of perceived institutional peer support being correlated with a lower level of depressive symptoms.

Bulut.S (2009) conducted a study titled *Late life depression: A literature review of late-life depression and contributory factors* found out that late-life depression, relative to early onset depression, appears to be less influenced by genetics and more influenced by environmental factors and contradicts findings of *literature* which has indicated that late-life depression is influenced by genetics. He also linked food and nutrition as contributing to the quality of life, improving or maintaining emotional status and decreasing depressive moods.

Further study on depression was carried out by Kim.O et al (2009) on *Loneliness, Depression and Health status of the institutionalized Elderly in Korea and Japan* with an aim to describe loneliness, depression and health status in Korean and Japanese institutionalized elderly and explore differences between the counties. Through interview, they were able to show that more Korean elderly had depressive symptoms than Japanese and they attributed this to less physical function of the Korean elderly and their perception of their general health to be poor. They thus conclude that loneliness and perception of general health were significant predictors of depression in Korean and Japanese subjects.

1.4 Definitions of core concepts

Depression

Depression refers to a wide range of mental health problems characterized by the absence of a positive affect (a loss of interest and enjoyment in ordinary things and experiences), low mood and a range of associated emotional, cognitive, physical and behavioral symptoms (National Collaborating Centre for Mental Health 2010 p. 17).

Prevalence

The prevalence of an illness or condition is the number of individuals who have the condition at any moment (WHO 2008 p.31).

Elderly

According to Just et al (2010 p.1), traditionally, elderly people have been defined as those aged 65 and older, but the origin of this definition is unknown.

Autonomy

Autonomy is the perceived ability to control, cope with and make personal decisions about how one lives on a day-to-day basis, according to one's own rules and preferences (WHO, 2002 p.13).

Reciprocal Determinism

Reciprocal determinism describes interactions between behavior, personal factors, and environment, where each influences the others (Glanz and Rimer 2005 p. 21)

1.5 DESCRIPTION OF DEPRESSION.

According to WHO (2009, p 19), Depression is a condition characterized by episodes of depressed mood. Each episodes characterized by lowering of mood, reduction of energy, and decrease in activity. Capacity for enjoyment, interest, and concentration is reduced, and marked tiredness after even minimum effort is common. Sleep is usually disturbed and appetite diminished. Self-esteem and self-confidence are almost always reduced and, even in the mild form, some ideas of guilt or worthlessness are often present. The lowered mood varies little from day to day, is unresponsive to circumstances and may be accompanied by so-called "somatic" symptoms, such as loss of interest and pleasurable feelings, waking in the morning several hours before the usual time, depression worst in the morning, marked psychomotor retardation, agitation, loss of appetite, weight loss, and loss of libido. (WHO 2009, p 19).Though depressive feelings are common, especially after experiencing setbacks in life, depressive disorder is diagnosed only when the symptoms reach a threshold and last at least two weeks (WHO 2009, p 19).

1.5.1 History of depression

According to Barrios.G. (1988 p.300), Delasiauve's quotation contains one of the earliest technical use of the word 'Depression'. By 1860 however, the word is already found in medical dictionaries: "applied to the lowness of spirits of persons suffering under disease" (Mayne, 1960, p.264 in Barrios.G 1988 p.300). Barrios.G (1988), also attributed the reason for the need of the term to its suggestion of both a physiological and metaphorical 'lowering' of emotional function and hence had the semantic capacity to name either a 'symptom' or a condition.

In the first (1885) of many editions of Régis's Manual, depression is defined as: "the state opposed to excitation", consisting of a reduction in general activity ranging from minor failures in concentration to total paralysis (Barrios.G 1988, p.301). According to him, General physicians seemed to also have preferred depression to melancholia or lypemenia, because perhaps the term evoked a 'physiological' explanation with Sir Wil-

liam Gull (of anorexia nervosa fame) using it as early as 1868 in his classical article "Hypochondriasis" and by the end of the century, depression had become a synonym of melancholia.

Kraeplein (1921) was also known to have used "depressive state" as a generic category (Barrios.G. 1988, p.302). Barrios also stated that the old notion of melancholia was refurbished with meaning and its transition to depressive illness was facilitated by Esquirol's concept of lympemania, which for the first time emphasized the primary affective natured of the disorder. (Barrios 1988 p.302).

According to Blazer. D.G (2003 p.249), depression is perhaps the most frequent cause of emotional suffering in later life and significantly decreases quality of life in older adults, with literature of late life depression exploding in recent years while many gaps in our understanding of late-life depression has been filled. He also concluded that, while treatment works, mood disorders in old age remains a big public health issue.

1.5.2 Difficulties faced with diagnosing depression

There are a wide range of problems associated with diagnosing depression in the elderly such as lack of diagnostic aids, somatization of depressive symptoms, diagnostic confusion between depression and dementia, and the reluctance of General practitioners (Gps) to apply diagnostic labels. The "Diagnostic and Statistical Manual of Mental disorders." is commonly used but Teriun et al.(2002) in Antigoni.F, and Theofanidis.D(2009 p.110), there is still is a lack of confidence in present systems of classification and this may explain why Gps remain reluctant to apply diagnostic labels in this field of care. Researchers have argued that psychological diagnosis to date cannot be confirmed by the use of technological devices or laboratory tests unlike physical disease that are quite visible and having clearly marked symptoms which can be diagnosed with wide range of objective test like x-rays, sophisticated position emission tomography,e.t.c

According to Callahan (2001) in F.Antigoni and D.Theofanidis (2009 p.109), Less is known about normal psychology than normal physiology, and it could therefore be said

that is why it is harder to distinguish between normal and pathological states in clients with emotional and mental disturbances.

Due to the broad ranged nature of the definition of depression and its covering a wide range of phenomena from a normal state of mood to a diagnosed illness there have been classification problems as regards a lack of confidence in present systems of classification. Numerous classification attempts to classify depression have been made and the Diagnostic and statistical manual of mental disorder (DSM-III R) of the American Psychiatric Association is widely used.

Some screening scales used are standardized screening scales like the Geriatric Depression Scale (GDS) or the CES-D (Center for Epidemiologic Studies Depression Scale)

Physicians may not also always recognize depression especially in elderly with physical co-mobidity due to the masking of depressive symptoms by somatic complaints and the presumption that depressive symptoms are attributed to the concurrent physical illness.

1.5.3 Depression treatment in institutions

Though depression is widely prevalent in institutional setting, evidence suggests it is not only under diagnosed but also undertreated. Antidepressants are the most widely used medical treatment and though they are considered safe and efficacious for most elderly, they do have side effects. Selective serotonin reuptake inhibitors (SSRIs) and other newer brands of antidepressants such as Venlafaxine are better tolerated than older tricyclic antidepressants but tolerability still remains a major concern with the use of antidepressants in treating depression in elderly population. There are growing calls for the use of other therapeutic approaches that are non- pharmacological (e.g., behavior therapy, cognitive stimulation therapy, psychoeducation, etc.) to augment the basic foundation of treatment which at the moment relies mainly on pharmacotherapy (e.g., antipsychotics, antidepressants, mood stabilizers, cognitive enhancers). Main antidepressants and other available forms of treatment are listed below.

Antidepressant	**StartingDose; Usual dose range**	**CYP450 Enzyme inhibition**	**Generic Availability**
Fluoxetine	10mg; 20- 30mg	Inhibits 3A 4,2C19, and 2D6	Yes
Paroxetine	10mg;20- 30mg	Inhibits2D6	Yes
Sertraline	25mg; 50 -100mg	Mild 2D6 inhibition	Yes
Citalopram	10mg;20- 30mg	Mild 1A2, 2C19, and 2D6 inhibition	Yes
Citalopram	5mg; 10 - 20mg	Mild 1A2, 2C19, and 2D6 inhibition	No
Venlafaxine(extended Release)	37.5mg;75 -150mg	Mild 2D6 inhibition	No
Bupropion(slow release)	150mg; 150-300mg	Inhibits2D6	Yes
Mirtazapine	7.5mg; 15-45mg	No significant effect	Yes

Table 1: *Comparation of Antidepressants Commonly Used In Nursing Home (Thakur and Blazer 2008)*

Other forms of treatment that are non-pharmacological include, electroconvulsive therapy, light therapy ,exercise, psychological treatments like cognitive-behavior therapy(CBT), Interpersonal therapy(IPT), bibliotherapy, psychodynamic psychotherapy, Reminiscence and life review.

2 THEORETICAL FRAMEWORK

According to Glanz and Rimer (2005), one reason theory is so useful is that it helps us articulate assumptions and hypotheses concerning our strategies and targets of interventions. Redding et al (2000),also described theoretical model as fundamentally guiding both our current and future understanding of health behavior, as well as providing directing for our research and intervention development.

Albert Bandura's (1986) Social Cognitive Theory is the main theory applied as a foundation in the answering of the research questions posed in this study and is one of the influential theories of health-related behaviors used not only as a tool in solving problems but also in Health promotion.

2.1 Health promotion

Health promotion is broadly defined as the process of enabling people to increase control over, and to improve their health (Glanz and Rimer 2005). Effective public health, health promotion, and chronic disease management programs help people maintain and improve health, reduce disease risks, and manage chronic illness. They can improve the well-being and self-sufficiency of individuals, families, organizations, and communities. Usually, such successes require behavior change at many levels, such as individual, organizational, and community (Glanz and Rimer 2005 p.4).

2.2 Albert bandura's (1986) social cognitive theory

Human behavior has often been explained in terms of one-sided determinism. In such modes of unidirectional causation, behavior is depicted as being shaped and controlled by environmental influences or driven by internal dispositions (Bandura 1989 p.2).Bandura (2004 p.143) describes Social cognitive theory as a multifaceted causal structure in which self-efficacy beliefs operate together with goals, outcome expectations, and perceived environmental impediments and facilitators in the regulation of human motivation, behavior, and well-being. He also stated that, Belief in one's effica-

cy to exercise control is a common pathway through which psychosocial influences affect health functioning. And that this core belief affects each of the basic processes of personal change—whether people even consider changing their health habits, whether they mobilize the motivation and perseverance needed to succeed should they do so, their ability to recover from setbacks and relapses, and how well they maintain the habit changes they have achieved. He also views Human health a social matter, not just an individual one.

Bandura (2004 p.144), also described Social Cognitive theory as specifying a core set of determinants and that The core determinants include *knowledge* of health risks and benefits of different health practices, *perceived self-efficacy* that one can exercise control over one's health habits, *outcome expectations* about the expected costs and benefits for different health habits, the health *goals* people set for themselves and the concrete plans and strategies for realizing them, and the *perceived facilitators* and social and structural *impediments* to the changes they seek.

According to Glanz and Rimer (2005), Social cognitive theory describes a dynamic process in which personal factors, environmental factors, and human factors exert influence on each other.

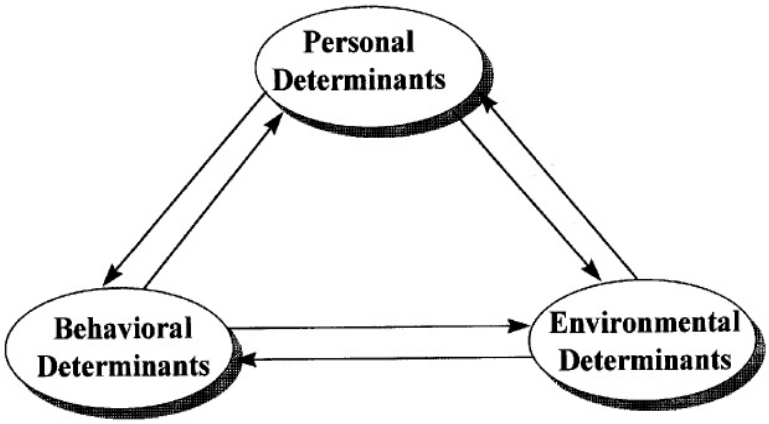

Fig 1: Schematization of triadic reciprocal causation in the causal model of Social cognitive theory (Bandura 2001)

Barbara Resnick (2008) in Smith,M.J and Liehr.P.R (2008 p.49) further explained that triadic reciprocity is the interrelationship among person, behavior, and environment; reciprocal determinism is the belief that behavior, cognitive and other personal factors,

and environmental influences all operate interactively as determinants of each other. Reciprocity does not mean that the influence of behavioral, personal factors and environmental influences are equal but depending of the situations, the influence of one factor may be stronger than another, and these influences may vary over time. Glanz and Rimer (2005) also described social cognitive theory as integrating concepts and processes from cognitive, behaviorist and emotional models of behavior change and that it includes many constructs. The table below best describes the various constructs of social cognitive theory.

Concept	Definition	Potential Change strategies
Reciprocal determinism	The dynamic interaction of the person, behavior, and the environment in which the behavior is performed	Consider multiple ways to promote behavior change, including making adjustments to the environment or influencing personal attitudes
Behavioral capability	Knowledge and skill to perform a given behavior	Promote mastery learning through skills training
Expectations	Anticipated outcomes of a behavior	Model positive outcomes of healthful behavior
Self-efficacy	Confidence in one's ability to take action and overcome barriers	Approach behavior change in small steps to ensure success; be specific about the desired change
Observational learning (modeling)	Behavioral acquisition that occurs by watching	Offer credible role models who perform the targeted

	the actions and outcomes of others' behavior	behavior
Reinforcements	Responses to a person's behavior that increase or decrease the likelihood of reoccurrence	Promote self-initiated rewards and incentives

Table 2: Social Cognitive Theory (Glanz and Rimer 2005)

2.2.1 Theoretical relevance to present study

Depression prevalence and effect of treatment in institutional care setting is viewed from the social cognitive theory perspective. This goes to say that the resultant high prevalence of depression cannot be attributed to a single determinism, but rather as a result of the interaction between the three factors. Depression prevalence in institutional setting can be viewed as affected by the combination of environmental factors such as nature of institution, types and suitability of intervention provided ,loss of familiar environment, e.t.c. all interacting with both personal determinants(cognitive, affective and biological events) and the behavior determinants (expectations, results. etc.).

For successful intervention to achieve the desired goal of health promotion, it must be noted that both social and physical environments may either act as a barrier or facilitate change. Reciprocal determinism must thus be taken into consideration in tackling the problem of high prevalence of depression in institutional setting despite advances in medical treatment.

3 METHODOLOGY

3.1 Literature review

Qualitative method was used for the study (literature review). Literature review has been defined by Aveyard, (2010 p1), as the comprehensive study and interpretation of literature that addresses a specific topic. Cook et al (1995) in Wright et al, (2007 p.23) describes a systematic review as "the application of scientific strategies that limit bias by the systematic assembly, critical appraisal and synthesis of all relevant studies on a specific topic". The reason for choosing this method is to present a very detailed or comprehensive view of the topic, especially as to reasons why there is high prevalence of depression in institutional setting despite its being considered a treatable ailment. The method helps the author narrows down and focus on the research questions and topic. It also helps the author to view the topic from a broader or wider perspective by not only identifying the problems that are related to depression prevalence and treatment in institutional care but also exploring the various interventions from a wider perspective. Literature review method chosen helps to shed more light on the problems posed by this research paper by presenting what has been written and researched on the topic, what may have probably been over looked as regards addressing the problems associated to on-field depression prevalence and treatment and the author hopes the method may even open up new meaning to the topic which literature review often does

3.2 Data collection

The search was conducted using the following databases EBSCO, CINAHL, and GOOGLE SCHOLAR with articles publications ranging from 2002 – 2012. Basic search criteria were limited to published literature written in English and Primary search terms were;*Depression Treatment* AND nursing home*, * Prevalence of depression amongst institutionalized elderly*, Prevalence of depression in elderly institutions*,

while limiting terms such as *treatment *,* institutional care*, and *Prevalence* was used.

3.2.1 Inclusion and exclusion criteria

Due to the vast published materials on depression**,** an extensive inclusion and exclusion criteria was established to identify literature that could help answer the research questions. Inclusion and exclusion criteria enable the literature reviewer to identify the literature that addresses the research question and that which does not. (Aveyard 2010, p71).

Inclusion criteria include;

- Published articles on depression prevalence amongst elderly people.
- Studies to determine the impact of depression treatment methods on depressed Institutionalized elderly.
- Published literature in English.
- Published articles between the years 2002 - 2012.

Articles that did not meet the inclusion criteria were excluded. Belonging to this category are articles that presents depression with some other form of illness, (e.g., depression and dementia), other articles that were unrelated to the research question, unpublished literatures and articles not written in English were also left out, and specific focus was given to but not limited to only institutional care setting.

3.3 Sampling process

A search was carried out using three electronic databases with the following key search terms as seen in table 3 below;

Database	Search terms	Year range	Results	Selected articles
Academic Search Elite (EB-SCO)	*Depression and elderly* AND *treatment *	2005- Present	334	5
GOOGLE SCHOLAR	* Prevalence of depression amongst insti-tutionalized elderly*	2002- Present	1260	4
CINAHL	* Non phar-macological treatment. AND depres-sion AND el-derly	2002- Present	4	1
DOAJ	Depression AND Elderly	2002- present	39	1
Academic Search Elite (EB-SCO)	*Depression treatment in Elderly*AND elderly*AND institution*	2002 - 2012	29	1

Table 3: Sampling process

With the main objective of this study being to highlight the high prevalence of depression in institutional setting despite depression being considered treatable, special attention was given to articles that gave details of treatment and interventions while effort was made to locate articles that show how elderly view certain treatment.

Since depression is considered treatable, and results from several Randomized control Trial researches (RCTs) seem to point to effectiveness of medication, in other to investigate the causes of high prevalence of depression in institutional care and treatment options available, article search included both quantitative and qualitative studies in other to grasp a better view of the underlying factors that are responsible for this high prevalence.

Articles for this study were selected after first reading abstracts of related articles and full text was then further read for detailed information if the abstract of the article in question provides evidence base facts to answer the research questions of this study. In line with systematic approach that is repeatable, information was recorded both in paper base and electronic form throughout the study and to avoid data loss, backing up was also done.

Finally, both online electronic books as well as books at the school library provided more useful resources during the entire duration of this study.

3.4 Data analysis

Data was analyzed using a *deductive content analysis* approach. According to Kyngas & Vanhanen (1999) in Elo.S and Kyngas.H (2008, p109), deductive content analysis is used when the structure of analysis is operationalized on the basis of previous knowledge and the purpose of the study is theory testing. Burns & Grove (2005) in Elo.S and Kyngas.H (2008) also described deductive content analysis as an approach that is based on an earlier theory or model and therefore it moves from the general to the specific. Deductive content analysis encompasses more than theory testing however and is described by Sandelowski (1995); Polit & Beck (2004); Hsieh & Shannon (2005) in Elo.S and Kyngas.H (2008) as generally based on earlier work such as theories, models, mind maps and literature reviews. Albert Bandura's (1986) Social Cognitive Theory guides this study and as such serves as the main foundation during the deduction pro-

cess. Since the main connotation of the theory is that personal factors, environmental factors, and human factors exert influence on each other. These factors will thus represent the main category during the analysis and deductions made subsequently in an attempt to answer the research questions of the study and find out what are the environmental, personal and human factors that affect the prevalence and treatment of depression in elderly living in institutions.

3.5 Presentation of the selected articles

AUTHOR/ YEAR	TITLE	AIM	METHOD	RESULT
D.R. Palompon et al, 2011	Predictors of Depression Among Institutionalized Elderly Clients	To find the predictors of depression among Institutionalized elderly clients.	descriptive design	institutionalized geriatric clients have higher tendency to develop depression specially those who lack support from the caregivers and family members.
P.Voyer and L.Scindel Martin, 2003	Improving geriatric mental health Nursing care: Making a case for going beyond psychotropic	To illustrate that while nurses can accomplish much to improve the well-being and mental health of elderly, their skills are often underutilized.	Literature review	High-quality mental health nursing care of elderly clients is a goal that does not seem to have yet been widely realized. And

	medications.			nurses can provide more expansive care for elderly patients using psychotropic drugs if they implement non pharmacological, supportive interventions, either as an alternative strategy or as adjunct therapy
N.G. Choi et al. 2008	Depression in older Nursing home residents: The influence of nursing environmental stressors,coping,and acceptance of group and individual therapy	To examine residents own understanding and perception of depressive symptoms, causes of their depression, their self-reported coping strategies, and their preference for acceptable depression interventions.	Semi-structured in-depth interview.	Residents attributed depression to loss of independence, freedom and continuity with their past life; feelings of social isolation and loneliness; lack of privacy and frustration at the inconvenience of having a roommate and sharing a bathroom; loss

				of autonomy due to the institutional regimen and regulations; ambivalence toward cognitively impaired residents; ever-present death and grief; staff turnover and shortage; and stale programming and lack of meaningful in-house activities. Self-reported coping mechanisms included religion and stoicism, a sense of reality, positive attitude and family support. In regard to depression treatment, the interviewees appeared to prefer nursing home programs that reduce their iso-

				lation over group or individual psychotherapy
Kuruvilla.T et al. 2006	Elderly Depressed patients: What are their views on treatment options?	To explore attitude of elderly clients with depression receiving secondary psychiatric care towards different types of treatment for depression	Structured interview	Psychotherapy was considered both effective and acceptable but not widely available while anti-depressants were considered effective and acceptable but likely to cause side effects. ECT was not regarded acceptable or effective.
Bergdahl.E et al,2007	Depression in the oldest old in urban and rural municipalities	To compare an urban and a rural old population regarding depression.	Cross-sectional study	Depression in old age appears to be a common cause of emotional suffering among the oldest old and in rural areas, depression was more often inadequately treated and it

				was also treated with inappropriate medications.
Stinson.C. K et al.2010	Use of a structured reminiscence protocol to decrease depression in older women.	To research alternative approaches to deal with depression.	Experimental two-group randomized control trial with repeated measure design.	Structured reminiscence decreases depression levels of women 60 years and older residing in assisted living facilities when offered twice weekly for 6 week duration to document significant improvement in depression score and engaging in reminiscence must occur longer than 3 weeks to measure a significant improvement in depression score.
Bogner.H. R et al. 2009,	Older primary care patients views regarding an-	To generate hypothesis regarding antidepressant use among older prima-	Mixed method design	Older adults taking antidepressant were more likely to be

	tidepressants: A mixed method approach	ry care patients		while and have more depression symptoms compared to older adults not taking antidepressants. Positive and negative themes emerged when participants discussed antidepressant use.
Thakur and Blazer,2008	Depression in Long – Term Care.	To review the diagnosis and treatment of depressive disorders in Long-term care settings.	Literature review	Up to 35% of residents in long- term care facilities experience either major depression or clinically significant depressive symptoms. These symptoms are often not recognized for at least 2 reasons: depression is not often the focus of physicians and nursing personnel and depression is fre-

				quently comorbid with other problems that are common in long term care, such as cognitive impairment, medical illness, and functional impairment. Depression in Nursing home setting can be treated effectively is diagnosed but while the foundation of treatment is pharmacotherapy, other therapeutic approaches such as exercise and psychological therapies may be of value.
Frazer.C. J et al. 2005	Effectiveness of treatment for depression in older people	To conduct a systematic review of evidence for the effectiveness of a range of possible treatment for de-	Systematic review	The treatment with the best evidence of effectiveness are antidepressants, electroconvul-

		pression in older people.		sive therapy, cognitive behavior therapy, psychodynamic psychotherapy, reminiscence therapy, problem- solving therapy, bibliography(for mild to moderate depression) and exercise. Limited evidence support the effectiveness of transcranial magnetic stimulation,dialectric behavior therapy, interpersonal therapy, light therapy(for people in nursing home or hospital) St John´s Wort and folate in reducing depressive symptoms
McDou-	Prevalence	To estimate the	Detailed as-	Prevalence of

gall F.A et al, 2007.	and symptomatology of depression in older people living in institutions in England and Wales	prevalence of depression and depressive symptomatology in participants living in institutions and compare these to people living in other settings.	sessment Interview	depression in those living in institutions was 27.1% compared to 9.3 % in those living at home. Symptoms related to depresses mood, severity of illness (e.g. wishing to be dead, future looking bleak) and some non-specific symptoms were more common with those living in residential home. Depression was significantly associated with younger age and higher functional disability in those living in institution.
F.Antigoni, and D.Theofan	Depression in the Elderly:Limits and	To provide a critical citation and discussion of the is-	Systematic literature review	Analysis revealed four major themes under

idis,2009	Challenges – a Nursing Perspective	sues involved when diagnosing depression of the elderly in the community.		which the papers fell: i) General difficulties in diagnosing depression, ii) The limitations GPs have when they diagnose depression, iii) The limits patients place on GPs during the diagnostic procedure and iv) The limits GPs and patients set on each other when depression is being considered
Lyne.K, J et al.2006.	Analysis of a care planning intervention for reducing depression in older people in residential care	To show the effect of A training and care-planning approach to alleviating depression and any health, social or emotional factors that might contribute to the resident's depression	quasi-experimental analysis	Clinically significant improvements in depression scores were associated with implementation of the care-planning intervention as evidenced by changes in

				scores on the Geriatric Mental State Sched-ule—Depression Scale

Table 4: Presentation of selected articles.

4. ETHICAL CONSIDERATION

According to Fouka.G and Mantzorou.M (2011 p.4) when nurses participate in research they have to cope with three value systems; society; nursing and science. The societal values about human rights, the nursing culture based on the ethic of caring and the researcher's values about scientific inquiry.

In line with Arcada's commitment to observe the Guidelines for Good Scientific Practice that the National Advisory Board on Research Ethics in Finland has issued in 2002, the author has tried as best as possible to observe the Universities guideline on what good scientific writing entails by being meticulous in conducting the research as well as in recording and reporting results. Work and results of other researchers were referenced and given credit to in line with good scientific principles. The author also tried to adhere to the supportive advice of the project supervisor as much as possible.

The author further tried to conform with the ethical codes of his professional discipline during the cause of research by not only considering primary commitment to patient (i.e. individual, family, group or community) but also the role of establishing, maintaining and improvement of healthcare environment that are vital to quality health care and consistent with the values of both individual and collective action. Swason (1993), in G.Fouka and M.Mantzorou (2011 p.8), stated that nursing views persons as a whole and health as a subjective and meaningful experience of integrating with the environment. The author thus tried to be as subjective as possible in investigating and presentation of results. Effort was made to avoid bias as to reasons why there is high prevalence of depression in Institutionalized care settings and results presented in like manner.

5 RESULTS

Results shows that there is high prevalence of depression in institutional care setting and the causes are associated to environmental factors, personal determinants(cognitive, affective and biological events) and the behavior determinants (expectations, results. etc.). These factors are better categorized and explained more clearly in figure 4.

5.1 Environmental determinants/ factors

Environmental factors may influence the prevalence and treatment of depression in institutional setting. Healthy Public Policy (2011p.4), describes environmental determinants of health as environmental influences that are involuntary, i.e., not a result of intentional choice. This means that, environmental factors that may affect the prevalence and treatment of depression in elderly institutions may be unintentional or persist unconsciously.

Gaugler, Leach, &Anderson, 2004; Kane et al..2004, Mosher-Ashley&Lemay, 2001 in N.G.Choi et al, (2008 p.536) describes the Nursing homes physical and social environment as one in which personal autonomy, self-determination, independence and privacy are largely compromised, affects residents psychosocial status, especially life satisfaction and depression, as well as physical and functional health and contributes to the high prevalence of depression among nursing home residents than among their community dwelling peers. Sefa Bulut (2009 p 21), also indicated that while literature has indicated that late life depression is influenced by genetic,situational,illness-related biological and psychosocial factors, however, late life depression, relative to early onset depression, appears to be less influenced by genetics and more influenced by environmental factors. The author thus categorized the environmental factors that may affect the prevalence and treatment of depression in elderly institutions from the reviewed articles to include, attitude towards living arrangement or how the elderly view their new environment ,perceived inadequacy of care ,loss of independence, freedom and continuity with past life, lack of social support or support from caregivers and family members, feeling of isolation and loneliness, lack of privacy, loss of autonomy due to institutional regimen and regulations, ambivalence towards cognitively impaired residents, ever present death

and grief's , staff turnover and shortage as well as stale programming and lack of meaningful in-house activities.

Also, diagnosing depression in the elderly is a complex challenge as many signs of depression are identical to symptoms present in different diseases or secondary side effects of medication consumption or to stressful event. General difficulties in diagnosing depression could become an environmental factor that also affects its prevalence in elderly institutional setting. F. Antigoni and D. Theofanidis(2009) listed several reasons that include a lack of diagnostic aids available for General practitioners, and While physicians have a wide range of objective test like X-ray sophisticated Positron Emission Tomography to reach accurate diagnose of physical illness, psychological diagnosis cannot be confirmed by the use of elaborate technological devices or laboratory test. They also explained that Somatization of depressive symptoms also pose a challenge for physicians when depression is associated with physical illness and that Difficulty can arise because of masking of depressive symptoms by somatic complaints or the presumption that symptoms are attributed to the concurrent illness. *General Practitioners* (Gps) also face diagnostic confusion between depression and dementia as both may present similar features. Other Research results have shown Gps sometimes mistakenly rate a client suffering from depression as demented. They pointed out that Gps also tend to be more interested in medical problems and less interested and attentive to their patients mental complaints and that Gp training curriculum is known to emphasis more on medicine rather than on psychiatry. Also mentioned was that Time constraints and workload is yet another problem that Gps face due to the fast growing numbers of nursing and residential homes. Gps don't seem to have the necessary time to visit clients in their nursing and residential homes as well as in embarking in multidisciplinary case conferences as used in hospitals and known to be the most comprehensive way of reviewing client's needs. With research showing that clients spent 5-6minutes on average with their Gps, it will be difficult for doctors to sufficiently listen to all the concerns by their clients. Also, Gps may also mistakenly view symptoms as normal consequence of ageing (Ageism).

In term of treatment environment, results shows that depression was more often inadequately treated as well as being treated with inappropriate medication. Psychotropic

drugs are often the first-line interventions used by health care professionals to treat mental health concerns of elderly despite the promising effect of alternative therapies and non-pharmacological approaches. Psychotherapy is not widely available despite its being considered effective and acceptable by elderly. Also while antidepressants were considered effective and acceptable, they are likely to cause side effects. Similar concern was expressed by C.K Stinson et al,(2010) stating that medication do not always decrease depression ,while Clancy& Bierman (2000) in C.K Stinson et al,(2010 p.665) described antidepressant medications as being sometimes expensive, frequently having numerous side effects and may not alleviate the disorder . *Tolerance* has been an issue as regards antidepressants use even with the introduction of newer, better tolerated antidepressants like selective serotonin reuptake inhibitors(SSRIs).Almost all antidepressant are associated with initial gastrointestinal(GI) side effect, increased anxiety and headache while certain SSRIs have far more serious side effect like the risk of developing hyponatremia,the risk of fall and hip fracture ,serotonin syndrome(restlessness ,lethargy ,renal failure), Older adults are more skeptical of diagnosis and treatment of depression with addiction a major concern with antidepressant use and most elderly .with depression view psychotherapy to be just as effective and acceptable a treatment for depression as anti-depressants.

Another environmental related issue results shows, was that there was also the problem of limited or lack of training in recognition of depression by staffs in general as well as nurses skills being often underutilized in improvement of wellbeing and mental health of the elderly. Nurses do not always engage in a therapeutic nurse- patient relationship with elderly people exhibiting mental health problems like depression. Lindeman et al,(2004);Penna,Paylor,& Soothill,(1995) in K.J,Lyne et al (2006),stated that lack of training, and management and peer pressure mean that care staff give priority to practical task rather than talking to residents.

5.2 Personal determinants/ factors

Bandura, A. (1999 p.2),described personal factors as being very much involved in regulating attention processes, schematic processing of experiences, memory representation and reconstruction, cognitively-based motivation, emotion activation, psychobiologic functioning and the efficacy with which cognitive and behavioral competencies are executed in the transactions of everyday life.

B. Engler (2008, p236), described personal determinants as *cognitive*, affective and *biological*. According to Blazer D. G. and Hybels C. F., (2005 p.2), the discovery of biological risk factors and their putative mechanisms has been a fertile area of basic and clinical research into the origins of late-life depression. They then went on to list biological factors that are related to the Origins of depression in later life to include genetics and heredity factors, neurotransmitter dysfunction, endocrine changes, vascular disorders, and medical co-morbidities. Biological factors that were found in the reviewed research articles and which may contribute to the prevalence and treatment of depression include the presence of cognitive impairment like dementia, change in brain structure related to cortical-striatal-pallidal-thalamus-cortical pathway, smaller size of the orbital frontal cortex in late life depression, smaller left hippocampal volumes in depressed clients who go on to develop dementia and comorbid medical conditions are some factors associated with depression as well as functional disability. Other factors related to disability like pain has been associated with depression.

5.3 Behavioral determinants

Peel .N.M et al (2005 p.299), defined behavioral factors as those that can be eliminated or reduced through lifestyle or behavioral changes. Behavioral factors should be taken into consideration in depression prevalence and treatment in institutionalized setting. To identity behavioral determinants that could be responsible for prevalence and treatment of depression in institutional setting, the author reviewed few articles on how the elderly feel about depression and its treatment. This was done in an effort to try to identify behavioral factors that are changeable.

There have been various studies on how the elderly view depression treatment. The author reviewed few articles that are related to the elderly perception of treatment, their expectations and acceptance of treatment. Treatment perception may be responsible for how well the elderly respond to treatment and how they perceive depression. Results from researches on how elderly feel about depression treatment and antidepressant use revealed both positive and negative themes. While some feel antidepressant influence positive mood change and it's beneficial as long as there is adherence to physician's prescription, there is also a feeling that medication is only a partial fix and that depression may be a complicated problem beyond the curative scope of medicine. They also feel that doctors don't have all the answers and finding the right drug is a trial and error. There was also a strong concern about becoming addicted to depression medication as well as a feeling of vulnerability due to ageing.

Based on the above, results on factors responsible for the prevalence of depression in elderly institutional care setting were classified as follows:

Main Category	Subcategory	Examples
Environmental determinants	Factors related to the institutionalized environment.	- Perceived inadequacy of care - loss of independence - loss of freedom and continuity with past life - Time constraints and workload of general practioners - underutilization of nurses skills - nurses lack of training in recognition and management of depression -inadequate treatment.

		- Medication side effect/ Non tolerance – More emphasis on medicine rather than on psychiatry in Gps training curriculum - institutional regimen and regulations - lack of social support or support from caregivers and family members - ambivalence towards cognitively impaired residents, -ever present death and grief's , - staff turnover and shortage -stale programming and lack of meaningful in-house activities
Personal determinants	Factors that are biologically related.	-presence of cognitive impairment - Change in brain structure - Functional disability -comorbid medical conditions
Behavioral Determinants	Factors related to expectations and results	***Both positive and negative themes emerged*** - some feel antidepressant

		influence positive mood change - Feeling that adherence to physicians prescription is important -A feeling that medication is only a partial fix -Feeling that depression may be a complicated problem beyond the curative scope of medicine - Feeling that doctors don't have all the answers - Feeling that finding the right drug is a trial and error - strong concern about becoming addicted to depression medication - Feeling of vulnerability due to ageing

Table .5 Categorization of factors responsible for the prevalence of depression in elderly institutional care setting.

6 DISCUSSION

One common stereotype of growing old is that there is a high chance of becoming depressed and this stereotype has fostered the exploration of depression as a natural aspect of ageing and how depression and age are related(D.R Palompon et al, 2011.p 129). A wide spread belief is noted that depression is a natural consequence of ageing but according to Meyers & Young(1997) in D.R Palompon et al,(2011) ,it is not.

New research findings have suggested that depression in late life occurs in the context of numerous social, physical, and related disability problems (Meyers & Young 1997 in D.R Palompon et al, 2011).This is similar to the findings of this research.

On the questions of what the causes of high prevalence of depression in institutional care are and how effective is depression treated in institutionalized care setting? The main findings are that personal factors, behavioral factors and Environmental factors all contribute to the high prevalence of depression in Elderly Institutions that is being experienced presently, and while Depression is treatable, it is often inadequately treated in elderly care facilities and treatment is usually limited to medication. Treatment is also affected by personal, behavioral and Environmental factors.

Personal factors that are biologically related and which contribute to the high prevalence of depression in institutionalized care settings has been highlighted by previous studies. S.Bulut (2009.p22), Stated that because ageing brings about much physical, psychological and cognitive impairment, each individual constitutes a unique case that needs to be assessed thoroughly. Institutionalized elderly people seem to be at increased risk of developing depressive symptoms due to frequently occurring chronic physical illness, a factor that is closely related to depression in old age (**G**odlove et al., 2000; Gurland et al., 1979; Henderson et al., 1993; Parmelee et al., 1992; Stek et al., 2003 in Jongenelis.K et al 2004)

Despite the influence of personal determinants, Bandura .A (2004 p.145), explained that the regulation of behavior is not solely a personal matter and that some of the impediments to healthful living reside in health systems rather than in personal or situational impediments. Results of the study show that environmental factors do contribute to the high prevalence of depression in elderly institutional care setting. Some important but

very much overlooked environmental factors revealed in the study were; underutilization of nurses skills, nurses lack of training in recognition and management of depression, inadequate treatment, staff turnover and shortage , institutional regimen and regulations, ambivalence towards cognitively impaired residents,.etc. . This findings is consistent with that of Gaugler, Leach, & Anderson, (2004); R.L. Kane et al, (2004); Mosher – Ashley & Lemay, (2001) in Choi N.G. et al (2008 p.536), who stated that the Nursing home physical and social environment, in which personal autonomy, self-determination, independence and privacy are largely compromised, affects residents psychosocial status, especially life satisfaction and depression, as well as physical and functional health.

While nurses lack of training skills ,staff turnover and shortage and institutional regimen and regulations seems well known in care settings, the problem of underutilization of nursing skills is a problem the author is conversant with ,having experienced it in practice. A report by White et al (2009) on "*Enhancing Nursing Role Effectiveness through Job Redesign"* describes the lack of focus on optimal role enactment as representing an underutilization of nursing knowledge and skill and potentially compromises the quality of care .The report went further to explain that Redesigning the work of nursing providers involves the purposeful creation of professional practice environments that facilitate adherence to standards of practice and promote excellence in patient care. Strategies aimed at optimizing the utilization of the knowledge, skills and capabilities of all healthcare providers are particularly critical to overcoming current and future workforce shortages and improving quality of care.

The author has also experienced staff underutilization in practice and while the author tried to rehabilitate and apply acquired theoretical knowledge in the cause of providing daily care, his effort was frowned at for reasons unknown despite positive response to rehabilitation. The author did feel underutilized and restricted to certain basic care. The answer may lie in a conversation the author had with a sympathetic work colleague who after listening to the author's explanation of the benefit of rehabilitation gave the following response: "But they are old".

While ageism may be one reason for staff underutilization in institutional care, more researches on staff underutilization in care facilities and the effect this may have on staff confidence and productivity are needed to reveal the true reasons.

With Global ageing ,anticipated increase in institutionalization and a likely increase in the amount of institutionalized elderly suffering from depression, There is no doubt that to tackle the problem will need viewing the problem in a multidimensional causative approach. This may mean viewing the problem not only from a biological point of view but also taking into consideration institutionalized environment effect as well as those that can be eliminated or reduced through lifestyle or behavioral changes(behavioral factors).

While biological related issues should be taking into consideration a more broader solution to the problem of high prevalence and treatment of depression in institutional care may include reducing the environmental related stressors by going beyond psychotropic medication and exploring other tested alternative non-pharmacological approaches, funding for the development of more tolerant drugs, improving nursing home environments, training and education of Nursing staff in mental health intervention skills, Eradicating staff Underutilization by promoting and encouraging professionalism through the maintaining of a professional practice environment that optimizes the utilization of knowledge and skills as well as taking advantage of multidisciplinary staff resources. Other solutions may include continuous development of innovative programs and meaningful in-house activities, promoting the need for equal emphasis on medicine and psychiatry in the curriculum of Gps.

Similarly, likely solution to behavioral factors or those factors that can be eliminated or reduced through lifestyle or behavioral changes may include, taking into consideration the elderly perception of depression and its treatment as well as their expectation and treatment result, Encouraging nurses to engage in a therapeutic nurse - patient relationship with elderly suffering from depression not only aiding better communication but also understanding the cause of depression and preventing relapse after treatment.

It may also be helpful to address issues that are linked to the elderly feeling vulnerable and continuous provision of treatment information to them about the various treatment

related side effects of medication they may experience, taking into consideration their fears about addiction to treatment drugs and discussing not only the availability of more tolerant treatment but also the reality of side effect and ways of notifying the facility when the situation does arise..

6.1 Validity and reliability

Reliability and validity are conceptualized as trustworthiness, rigor and quality in qualitative research paradigm (N. Golafshani, 2003 p.604**).** Within the conduct of inquiry itself, verification strategies that ensure both reliability and validity of data are activities such as ensuring methodological coherence, sampling sufficiency, developing a dynamic relationship between sampling, data collection and analysis, thinking theoretically, and theory development. (Morse J.M.et al 2002.p.11)

Systematic literature review was carried out to present a comprehensive and detail view of the topic while Articles for the literature review were searched in multiple databases, to ensure sampling sufficiency. The selected articles were published in different countries and in different international journals ranging from mental health, to caring sciences and psychiatry. Care was taken in the selection of articles to ensure articles selected are restricted to the research questions.

Since theory guides the study, the author ensured a relationship between the sampling, data collected and data analysis by thinking theoretically and making deductions based on existing theoretical knowledge.

6.2 Critical review

The major finding in the research was that physical, biological and personal factors all contribute to depression prevalence and treatment in institutionalized care setting. The method chosen was content analysis and one of its advantages is that large volumes of textual data and their various sources can be easily handled in supporting evidence. Its disadvantages are that content relates to research questions that are ambiguous or too extensive (Elo.S and .kyngäs.H 2007). Due to limitation in the amount of articles that

could be analyzed, the author experienced difficulties in the selection of articles as regards answering the research questions. For example, very few articles were selected in investigation as to how elderly feel about treatment, and while deductions were made thereof, the number of articles selected may not sufficiently present the exact picture of how the elderly feel about treatment.

The research was also based on theory and though theory often serve as useful tools for developing research ideas as well as testing those ideas on new knowledge, theory however narrows the view of the topic and may stop us from searching for new facts. Applying sociocognitive theory is just one way of viewing the problems of high prevalence and treatment of elderly with depression in institutionalized care setting and the results may not entirely represent all aspects of the problems highlighted in this research.

Finally, there is no single theory that can explain all aspects of a given phenomenon or problem and this is true as not all aspects of sociocognitive theory was presented or explained in relation to the research questions.

6.3 The meaning for practice

The models of health promotion and disease prevention have undergone several generational changes. We have shifted from trying to scare people into health, to rewarding them into health, to equipping them with self-regulatory skills to manage their health habits, to shoring up their habit changes with dependable social supports. These transformations have evolved a multifaceted approach that addresses the reciprocal interplay between self-regulatory and environmental determinants of health behavior. Social cognitive theory addresses the sociostructural determinants of health **as** well **as** the personal determinants (Bandura 1998.p 623).

Due to these changes in health models and its evolution into a multifaceted approach, there is also a need for this change to reflect in practice. Care institution need to view the problem of high prevalence of depression and its treatment from a multifaceted angle, while considering the reciprocal interplay of personal factors, behavioral factors as well as environmental determinants.

6.4 Need for further studies

While research result have shown the effect of Personal, environmental and behavioral determinants in the prevalence and treatment of depression in institutionalized care settings, there is need for further studies on the relative influence of these factors(determinants) on the prevalence and treatment of depression in institutional care setting. This may aid in providing knowledge and drawing attention to the problem of high prevalence in this setting as well as providing caregivers, health care professionals and care institution management more specific information regarding the problem. It may also provide information regarding the relative proportion of intervention type needed in specific situation as well as create wider options in planning for intervention in elderly institutionalized care settings.

More studies are also needed on elderly perception of depression treatment methods, influences of care staff education on depression prevalence as well as environmental impediments to depression and likely solutions to that aspect.

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